DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

AND PLAN OF CORRECTION

OTC 4/9/12

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

PRINTED: 02/23/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

		445160	B. WIN	G	C 02/24/2012	
	PROVIDER OR SUPPLIER LD REHABILITATION	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAYFIELD DRIVE SMYRNA, TN 37167	0212-112012	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLE	TION
F 166 SS=D	A resident has the r	TO PROMPT EFFORTS TO NCES ight to prompt efforts by the evances the resident may	F 1	Incontinent care was provided to Resident #3 by LPN #1 and CNT		
	have, including thos of other residents.	e with respect to the behavior		upon discovery that incontinent can needed, CNT in-serviced on proper incontinent care 2-8-12.	re was er 2-8-1	2
	by: Based on medical r grievance log, obser	is not met as evidenced record review, review of the roation and interview, the live a grievance for one (#3) of wed.		On 2-14-12, Facility staff conducted Interviews of Resident's and / or responsible party related to any con or grievances and a grievance form completed when indicated. Grievar will be followed up on by departme	cerns 2-14-1 was aces	12
1	The findings include Resident #3 was add	mitted to the facility on March		manager and results will be reported than 3-23-12 to the Administrator:	3-23-1	2
	Thrive, Psychosis, G Dementia, Hyperten	ses including Adult Failure to Seneralized Anxiety, Senile sion, Paralysis Agitans, ux Disease and Depressive		Department managers in-serviced by Administrator on 2-16-12 to complet a grievance form if indicted by a concountry voiced during weekly customer services.	ern 2-10-1	2
	dated January 23, 20 had short and long-to required extensive a daily living (ADL) and and bladder. Review of a grievand December 29, 2011,	revealed the family of concern regarding a delay in ene after a urinary		Administrator will utilize a tracking f to ensure follow up on grievances voi during weekly customer service calls completed by Department managers. Administrator to monitor on an ongoi basis.	2-16-12	2
	Observation and inte	rview in the resident's room				
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNAT	TUDE	TITLE	(YE) DATE	

by deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued organ participation.

RM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WJYU11

Facility ID: TN7503

If continuation sheet Page 1 of 11

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION NG	(X3) DATE SI COMPLE	
		445160	B. WING		1	C 4/2012
	ROVIDER OR SUPPLIER D REHABILITATION	CENTER		REET ADDRESS, CITY, STATE, ZIP CODE 200 MAYFIELD DRIVE SMYRNA, TN 37167		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	Licensed Practical Nurse revealed LPI on the left side and Observation revealed brief. Observation movement on both with a foul odor from LPN #1 confirmed or resident's buttocks. Interview on Februar the training room, we confirmed the famil December 29, 2017 resident in need of C/O #29146, #2927	2, at 3:45 p.m., with the Nurse (LPN #1)/Treatment N #1 positioned the resident unfastened the brief. ed no bowel movement in the revealed dried bowel buttocks and the coccyx area in the resident. Interview with dried bowel movement on the and coccyx with a foul odor. ery 9, 2012, at 10:20 a.m., in with the Administrator y voiced a grievance on I, related to finding the incontinence care.	F 166	Through monthly CQI (Continuous Improvement) meeting, committee the number of grievances and the ti of resolution. Any report of non-cowill require follow-up interventions	will track imeframe ompliance	3-23-12
F 280 SS=D	The resident has the incompetent or other incapacitated under participate in plannichanges in care and A comprehensive of within 7 days after the comprehensive associated interdisciplinary team physician, a register for the resident, and disciplines as determined to the extent put the resident, the resident incomprehensive in the resident in the re	e right, unless adjudged erwise found to be the laws of the State, to ng care and treatment or	F 280	Careplan of Resident #3 was review careplan team and corrected to reflet plan of care including interventions reduce the risk of further injury from the zippered robes.	ect current s to	2-15-12

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Van anna an		(X3) DATE SI COMPLE	
	445160				C 4/2012
	CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 200 MAYFIELD DRIVE SMYRNA, TN 37167		412012
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
Continued From pa each assessment.	ge 2	F 28	80		
by: Based on medical and interview, the fi plan for one resider abrasion of nine res The findings include Resident #3 was ac 1, 2005, with diagne Thrive, Psychosis, Dementia, Hyperter Gastrointestinal Re Disorder. Medical record revidated January 23, 2 had short and long- required extensive daily living (ADL). Medical record revice to all living (ADL).	record review, observation acility failed to update the care of (#3) who received an sidents reviewed. ed: dmitted to the facility on March oses including Adult Failure to Generalized Anxiety, Senile ansion, Paralysis Agitans, flux Disease and Depressive ew of the Minimum Data Set 2012, revealed the resident assistance with all activities of ew of a hospice note dated evealed, "Skin assessed per Nurse (LPN)/Treatment assistance with all activities of exercise (LPN)/Treatment (IPN)/Treatment (IPN)/Tr	a o	will review the skin integrity care of all current residents and, then quarterly thereafter. This will be monitored by the Dir of Nurses. Completion of initial Each discipline will orally review careplan during careplan team m with discussion as needed. All disciplines are required to atte through Friday stand up meeting. Each discipline is responsible for planning any issues/concerns dis during the meeting that pertains the discipline. Director of Nursing/A	ector review: their own eeting nd the Monday care cussed their dministrator	3-30-12
Medical record revi	ew of a nurse's note by the				
	Continued From pareach assessment. This REQUIREMENT by: Based on medical and interview, the faplan for one resider abrasion of nine resider abrasion of nine resider abrasion of nine resident #3 was ac 1, 2005, with diagnoral trive, Psychosis, Dementia, Hyperter Gastrointestinal Redical record revidated January 23, 2 had short and long-required extensive daily living (ADL). Medical record revidence of the control of the c	A45160 ROVIDER OR SUPPLIER D REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to update the care plan for one resident (#3) who received an abrasion of nine residents reviewed. The findings included: Resident #3 was admitted to the facility on March 1, 2005, with diagnoses including Adult Failure to Thrive, Psychosis, Generalized Anxiety, Senile Dementia, Hypertension, Paralysis Agitans, Gastrointestinal Reflux Disease and Depressive Disorder. Medical record review of the Minimum Data Set dated January 23, 2012, revealed the resident had short and long-term memory problems and required extensive assistance with all activities of	ROVIDER OR SUPPLIER DREHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to update the care plan for one resident (#3) who received an abrasion of nine residents reviewed. The findings included: Resident #3 was admitted to the facility on March 1, 2005, with diagnoses including Adult Failure to Thrive, Psychosis, Generalized Anxiety, Senile Dementia, Hypertension, Paralysis Agitans, Gastrointestinal Reflux Disease and Depressive Disorder. Medical record review of the Minimum Data Set dated January 23, 2012, revealed the resident had short and long-term memory problems and required extensive assistance with all activities of daily living (ADL). Medical record review of a hospice note dated February 6, 2012, revealed, "Skin assessed per (Licensed Practical Nurse (LPN)/Treatment Nurse #1) et (and)Risk Manager. Resident has long red area on lower left side of abdomen towards hip areaRisk Manager et (Treatment Nurse) to reinforce (with) facility staff need to be careful and assess all patients for possible injury related to positioning, transferring all patients"	ROVIDER OR SUPPLIER DREHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES SMYRNA, TN 37167 PROVIDER'S PLAN OF CORR (EACH DEFICIENCY) MUST BE PRECEDED BY FULL REOULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 each assessment. F 280 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to update the care plan for one resident (#3) who received an abrasion of nine residents reviewed. The findings included: Resident #3 was admitted to the facility on March 1, 2005, with diagnoses including Adult Failure to Thrive, Psychosis, Generalized Anxiety, Senile Dementia, Hypertension, Paralysis Agitans, Gastrointestinal Reflux Disease and Depressive Disorder. Medical record review of the Minimum Data Set dated January 23, 2012, revealed the resident had short and long-term memory problems and required extensive assistance with all activities of daily living (ADL). Medical record review of a hospice note dated February 6, 2012, revealed, " Skin assessed per (Licensed Practical Nurse (LPN)/Treatment Nurse #1) et (and)Risk Manager et (Treatment Nurse) to reinforce (with) facility staff need to be careful and assess all patients for possible injury related to positioning, transferring all patients"	ROVIDER OR SUPPLIER DREHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SMYRNA, TN 37167) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SMYRNA, TN 37167) CONTINUED FROM THE PROPERTIES OF THE PROPER

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLET						
		445160	B. WING	1	02/	C 24/2012
MAYFIE	PROVIDER OR SUPPLIER LD REHABILITATION		S	STREET ADDRESS, CITY, STATE, ZIP COD 200 MAYFIELD DRIVE SMYRNA, TN 37167		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	revealed, "Staff rep 2012) that an abras and left lower abdo the time. Upon inversion to have been lying connects with a zip Technician) remove repositioned reside dinnerstates that that time and did not second round where assessment, the ablines of rough edge assessing the abras displaying a similar the statement that the consider bring(ing) zippers as a prevent replied by stating the how to do their jobs in these housecoats. Medical record reviewed revealed the care plaster the resident rezipper on February interventions to reduce the resident's room, Nurse (LPN #1)/Tre resident lying in bed with a zipper. Observation on the left lower aboutward toward the	#2 dated February 9, 2012, orted on 2-4-12 (February 4, sion was noted to the left hip men. No blood was noted at estigation, resident was noted on her housecoat, which perCNT (Certified Nursing ed the housecoat and not to prepare for peri-care was not required at ot notice any markings until the housecoat and notice any markings until the housecoat. Upon prasion shows clean, even so with no broken skin. While sion, (family) was present and housecoat. This writer made the family may need to in coats with snaps instead of tative measure(Family) at people here need to learn, and we will continue to bring s" Bew of the current care plan and had not been updated, ceived the abrasion from the 4, 2012, to include use the risk of further injury obes. Fruary 8, 2012, at 3:45 p.m., in with Licensed Practical atment Nurse revealed the wearing a gown and a robe ervation revealed a red area domen extending upward and	F 28	Monday through Friday stand- committee members will be in on this procedure Results of the Care plan interv Follow-up will be reported dur monthly Continuous Quality In meeting. The Director of Nurses and Ca Coordinator will be responsible monitor this process and insure compliance.	entions and ring the mprovement re plan e to	3-13-12

AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE S	
		445160	B. WIN	G	02/	C 24/2012
	PROVIDER OR SUPPLIER LD REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CC 200 MAYFIELD DRIVE SMYRNA, TN 37167		12012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	the red area match the robe and revea along the abrasion.	servation revealed the width of ed the width of the zipper on led multiple, tiny rough areas	F 2	80		
	on February 14, 20 Director of Nursing investigation of the the abrasion was ca the zipper. Continu confirmed the DON care plan and confi	v and medical record review 12, at 10:35 a.m., with the (DON) revealed the facility abrasion led staff to determine aused by the resident lying on led interview with the DON had reviewed the current rmed the care plan had not interventions to reduce the risk or zippered robes.				
F 312 SS=D	A resident who is undaily living receives	ARE PROVIDED FOR IDENTS nable to carry out activities of the necessary services to cion, grooming, and personal	F 31	Incontinent care was provid Resident #3 by LPN #1 and CNT upon disc that incontinent care was no CNT in serviced on proper care per facility policy and	overy eeded. incontinent	
	by: Based on medical review, observation failed to ensure one			on 2-8-12	procedure	2-8-12
	Resident #3 was ad	mitted to the facility on March				

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X3) DATE SURVEY COMPLETED				
			A. BUIL B. WING			C	
		445160	15. *****			02/24	/2012
	D REHABILITATION	CENTER		20	EET ADDRESS, CITY, STATE, ZIP CODE 0 MAYFIELD DRIVE MYRNA, TN 37167		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 312	Thrive, Psychosis, Dementia, Hyperte Gastrointestinal Redisorder. Medical record revidated January 23, had short and long required extensive daily living (ADL) a and bladder. Review of the facilicare revealed, "Fadequate skin care damageTo provide preserves resident material from the rollet tissueWashareaGo to the other bed rail; expose the wash, rinse, and disconsidered Practical Nurse revealed LP on the left side and Observation revealed LP on the lef	oses including Adult Failure to Generalized Anxiety, Senile nsion, Paralysis Agitans, offlux Disease and Depressive liew of the Minimum Data Set 2012, revealed the resident term memory problems; assistance with all activities of nd was incontinent of bowel lity's policy for incontinence PURPOSEto ensure eTo control odor, prevent skin de care in a manner that adignityRemove the fecal esident's buttocks area using n, rinse and dry the buttocks her side of the bed; lower the e resident's buttocks area; ry the exposed area" Interview in the resident's room 12, at 3:45 p.m., with the Nurse (LPN #1)/Treatment of unfastened the brief. Ited no bowel movement in the revealed dried bowel in buttocks and the coccyx with the resident. Interview with LPN it bowel movement on the sand coccyx with a foul odor.	F.3	12	On 2-14-12, Facility staff conducted Interviews of Resident's and / or responsible party related to any coror grievances and a grievance form completed when indicated. Grievate will be followed up on by department manager and results will be reported than 3-23-12 to the Administrator. Nursing staff in-serviced on inconcare per facility policy and processarted on 2-10-12 with completion by 3-23-12. Nurse Administration (Restorative Nurse, Risk Manager Nurse, Staff Development Nurse (2) Unit Manager, and Medical Records Nurse) will provide incontinent care competed on 5 CNT's until all current CNT's have successfully complete an incontinent care competency. Incontinent care competencies with be conducted during new employed orientation and during CNTs annual Begin; 3-23-12 DON will monitor compliance of incontinent care competencies and report results in monthly Continual Quality Improvement meeting.	ncerns n was nnces ent ed no later tinence dure on n, Treatment ncies ed	3-23-12 3-23-12
F 323	C/O #29146, #292 483.25(h) FREE C		F	323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/23/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION				PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445160	B. WING		1	C 24/2012
	ROVIDER OR SUPPLIER		20	EET ADDRESS, CITY, STATE, ZIP CODE DO MAYFIELD DRIVE MYRNA, TN 37167		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPOPULATION DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312	1, 2005, with diagrative, Psychosis Dementia, Hyper Gastrointestinal In Disorder. Medical record redated January 23 had short and lor required extensive daily living (ADL) and bladder. Review of the facare revealed, " adequate skin cadequate	gnoses including Adult Failure to s, Generalized Anxiety, Senile tension, Paralysis Agitans, Reflux Disease and Depressive eview of the Minimum Data Set 3, 2012, revealed the resident ng-term memory problems; we assistance with all activities of and was incontinent of bowel cility's policy for incontinencePURPOSEto ensure areTo control odor, prevent skin ovide care in a manner that ent dignityRemove the fecal eresident's buttocks area using ash, rinse and dry the buttocks other side of the bed; lower the the resident's buttocks area; dry the exposed area" If interview in the resident's room 2012, at 3:45 p.m., with the call Nurse (LPN #1)/Treatment LPN #1 positioned the resident and unfastened the brief. Interview with LPN the resident. Interview with LPN the resident. Interview with LPN ried bowel movement on the cks and coccyx with a foul odor.	F 312	Unit Managers will randomly double check 5 residents per day for adequate ADL care times 5 to decrease to 3 residents per day and then monthly or as needed. Any trends and /or issues discord During monitoring period will reservice training and / or discinaction, given the level of the issues.	days y, 5 days 5 days attinued equire plinary	3-30-12
F 32	C/O #29146, #2 3 483.25(h) FREE		F 32	3		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NO. 023000	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		445160	B. WIN				C 4/2012
	ROVIDER OR SUPPLIER D REHABILITATION	CENTER	1	2	REET ADDRESS, CITY, STATE, ZIP CODE 00 MAYFIELD DRIVE MYRNA, TN 37167	, OZ/Z-	7/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	37.07	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323 SS=D	The facility must en environment remain as is possible; and		F;	323	CNT in serviced related to supervision of residents to prevent injury on 2-1 All nursing staff to be in serviced resupervision of residents to prevent completed by;3-23-12.	7-12. clated to injury,	2-17-12 3-23-12
	by: Based on medical facility investigation the facility failed to prevent an abrasion The findings include Resident #3 was ac 1, 2005, with diagnor Thrive, Psychosis, Dementia, Hyperter Gastrointestinal Re Disorder. Medical record revidated January 23, 2 had short and long- required extensive a daily living (ADL). Medical record revir February 6, 2012, re (Licensed Practical Nurse #1) et (and)	record review, review of a , observation and interview, supervise one resident (#3) to n of nine residents reviewed. Imitted to the facility on March oses including Adult Failure to Generalized Anxiety, Senile nsion, Paralysis Agitans, flux Disease and Depressive The work of the Minimum Data Set 2012, revealed the resident term memory problems and assistance with all activities of the work of a hospice note dated evealed, "Skin assessed per Nurse (LPN)/Treatment .Risk Manager. Resident has wer left side of abdomen	×		Unit manager or designee will randomonitor 10 residents per week to assappropriate supervision of Resident prevent injury. Director of Nursing or designee will compliance weekly times four then thereafter. Compliance will be reviewently in Continued Quality Imprimeeting. Begin;	sure 's to l monitor monthly ewed	3-12-12

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445160	B. WI	NG_		Tanana and Tanana	C 4/2012
NAME OF PROVIDER OR SUPPLIER MAYFIELD REHABILITATION CENTER			2	REET ADDRESS, CITY, STATE, ZIP CODE 200 MAYFIELD DRIVE SMYRNA, TN 37167			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	towards hip area Nurse) to reinforce careful and assess related to positioning the manager of the providing periodical that the bring(ing) in coats as a preventative restaing that people their jobs, and we housecoats" Review of a writter Manager dated Fe with the Certified N first reported the a Nurse (LPN) #2 realready in bed duri personal night gow When (CNA) #1 personal night gow Whe	Risk Manager et (Treatment (with) facility staff need to be all patients for possible injurying, transferring all patients" iew of a nurse's note by the 1#2 dated February 9, 2012, ported on 2-4-12 that and to the left hip and left lower of was noted at the time. Upon ent was noted at the time. Upon ent was noted to have been coat, which connects with a certified Nursing Technician) ecoat and repositioned resident erstates that peri-care was at time and did not notice any second round whenwas at time and did not notice any second round whenwas at time and displaying a This writer made the family may need to consider with snaps instead of zippers measure(Family) replied by here need to learn how to do will continue to bring in these and statement by the Risk bruary 9, 1012, of an interview dursing Assistant (CNA #1) who brasion to Licensed Practical vealed, "noted (resident) ng walking rounds with a reformed the first round for the circle and brief checknoted	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445160	B. WI			C 02/24/2012	
NAME OF PROVIDER OR SUPPLIER MAYFIELD REHABILITATION CENTER			2	REET ADDRESS, CITY, STATE, ZIP CODE 100 MAYFIELD DRIVE 5MYRNA, TN 37167			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	resident lying onli resident. After noti dryremoved the crepositioning to be (CNA #1) performe around the 6 o'clood the resident require providing carenot to the left hip and a (CNA)to verify the was confirmedthe nursedenies any and repositioning of shift" Review of a writtent Licensed Practical revealed, "Was call was lying in bed(brief whennoticed asked me to check onback dressed with turning (resided checkedabrasion bleeding or open a anything in bed, sid areas. Wheelchair found." Observation and in at 3:45 p.m., in the #1/Treatment Nurse of the stoward the left hip of the	eft side with the coat under the ng the resident was coat and provided turning and ready for dinner. After dinner d a second round, sometime k (p.m.) hour, and noted that ed incontinence care. While ted abrasion that was still redubdomenasked the other at it was a new spot, which	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445160	B. WII	NG		02/:	C 24/2012
NAME OF PROVIDER OR SUPPLIER MAYFIELD REHABILITATION CENTER		-1	20	REET ADDRESS, CITY, STATE, ZIP COD 00 MAYFIELD DRIVE MYRNA, TN 37167			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	matched the width revealed multiple, abrasion. Intervie the time of the obinvestigation determine the robe. Interview on February the training room, confirmed the resileft abdomen which investigation, the by the resident lying Interview on February the conference roweled two Certinformed LPN #2 3:00 p.m., to 11:00 resident's left lower interview revealed assistance with befrom the bed. Conconfirmed the appearant Continued interview the resident's wheeldges which might none were found. The resident's family the resident lying of the injury determine the resident lying of the light abrasion interview resident lying of the resident lying of the light abrasion interview resident lying of the light abrasion interview resident lying of the light abrasion was of the injury determined the resident lying of the light abrasion was	n of the zipper on the robe and tiny scabbed areas along the ew with the Treatment Nurse at servation revealed the facility's rmined the abrasion may have he resident lying on the zipper of uary 9, 2012, at 10:20 a.m., in with the Administrator ident received an injury to the ch, after initiating an facility determined was caused ng on the zipper of the robe. uary 9, 2012, at 10:55 a.m., in om, with LPN #2/Unit Manager ified Nursing Assistants on February 4, 2012, on the 0 p.m., shift of an injury to the er abdomen. Continued I the resident required extensive ed mobility and a lift for transfers intinued interview with LPN #2 a on the left lower abdomen ce of a "little railroad track." ew confirmed LPN #2 checked elechair, bed and sling for rough at have caused the injury and Continued interview revealed ily had first raised the possibility caused by the zipper in the alts of the facility's investigation mined the injury was caused by	F:	323			

ORM CMS-2567(02-99) Previous Versions Obsolete

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 02/23/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
		445160				C 02/24/2012
	ROVIDER OR SUPPLIER D REHABILITATION	CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAYFIELD DRIVE SMYRNA, TN 37167			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	first observed the restriction between 4:30 p.m. was lying on the leconfirmed CNA #1 required "a little bit resident required erepositioning. The resident's skin at the land denied the respain or discomfort Continued interview observed the residents.	resident on February 4, 2012, and 5:00 p.m., the resident ft side. Continued interview removed the robe which of strength" because the extensive assistance with CNA denied observing the ne time the robe was removed ident had any expression of when the robe was removed. We confirmed when CNA #1 ent at 6:00 p.m., the CNA sion on the abdomen and left end the charge nurse.	F 323			

Facility ID: TN7503

Event ID: WJYU11

If continuation sheet Page 11 of 11